Arizona Health Care Cost Containment System
Arizona Department of Health Services
Division of

Behavioral Health Services

Report for Contract Year 2005



External Quality Review Organization Annual Report



Submitted by HCE QualityQuest, Incorporated Phoenix, Arizona

EQRO Annual Report Contract Year 2005 Behavioral Health Services

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EXECUTIVE SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS) is the state Medicaid agency (Title XIX). AHCCCS also administers the Title XXI KidsCare State Children's Health Insurance Program. AHCCCS contracts with the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) to serve as the single state authority providing coordination, planning, administration, regulation, and monitoring of all facets of the Arizona Medicaid behavioral health managed care system. ADHS/DBHS is designated as a Prepaid Inpatient Health Plan (PIHP). The contract between AHCCCS and ADHS/DBHS stipulates the standards for access, structure and operations, and quality measurement and improvement.

ADHS/DBHS contracts with community-based organizations, known as Regional Behavioral Health Authorities (RBHAs), which function as health maintenance organizations to administer behavioral health services throughout the state. Arizona is divided into six geographic service areas (GSAs) served by five RBHAs and two Tribal Regional Behavioral Health Authorities (TRBHAs). For the period of this CY 05 EQRO Annual Report, the five RBHAs have been listed.

- Community Partnership of Southern Arizona (CPSA)
- The Excel Group (Excel)
- Northern Arizona Behavioral Health Authority (NARBHA)
- Pinal-Gila Behavioral Health Association (PGBHA)
- ValueOptions

Each of the RBHAs contracts with a network of service providers to deliver a range of behavioral health services. Some RBHAs provide direct services. Services include treatment programs for children and adults, a continuum of services for children with serious emotional disturbance, and services for adults with mental health problems and/or substance abuse disorders.

AHCCCS monitors and evaluates ADHS/DBHS compliance through program-specific performance measures, performance improvement projects (PIPs), review and analysis of periodic reports required by the contract, and an annual Operational and Financial Review (OFR). In compliance with the Balanced Budget Act (BBA) of 1997, AHCCCS contracted with an External Quality Review Organization (EQRO) to review the behavioral health quality-monitoring activities of ADHS/DBHS, including review of a selected PIP and the process and findings of the annual OFR. Additionally, the behavioral health EQRO validated one performance measure reported by ADHS/DBHS through its Independent Case Review (ICR) contractor's 2004 ICR Report. The EQRO is responsible for writing the annual report for submission by AHCCCS to the Centers for Medicare & Medicaid Services (CMS), consistent with the CMS protocols for the three required elements of external quality review. This EQRO Annual Report is for the

behavioral health services contract year July 1, 2004 through June 30, 2005, referred to as CY 05.

AHCCCS required the EQRO to test the reliability of the two measures of Coordination of Care (CoC) included in the 2004 Independent Case Review (ICR) annual report. These ICR measures were as follows.

- 1. Standard 9. The disposition of the referral from the Primary Care Physician (PCP) or Health Plan was communicated by the behavioral health provider to the PCP or Health Plan within 30 days of receiving the request for service.
- 2. Standard 10. Behavioral health care was coordinated with the member's PCP as required.

The ICR contractor selected a random sample of 1,559 cases, which was sufficient to provide a 90% confidence level and five (5) percent margin of error at the GSA level. However, the confidence level and error rate were not assured for each measure, as a given measure was only applicable to a sub-set of the ICR sample. The Standard 9 CoC measure was only applicable to 101 of the 1,559 cases, and the Standard 10 CoC measure was applicable to 560 cases of the 1,559 ICR sample.

AHCCCS set performance expectations for the percentage of behavioral health care recipients whose care was coordinated in accordance with each of the standards. The minimum threshold expectation was 60%, the goal was 75%, and the benchmark was 90%. The statewide performance for each of the two CoC measures, as reported by the 2004 ICR for CY 05, exceeded the minimum threshold of 60% for both adults and children, and exceeded the goal of 75% for children across both measures. Standard 9, communicating the disposition of a referral was somewhat improved in CY 05 compared to earlier years. Standard 10, coordinating behavioral health care as required with the member's PCP, was improved for both adults and children in CY 05 compared to the previous two years.

The EQRO re-abstracted data from a sample of 30 of the ICR cases for each of the two CoC performance measures to test the reliability of the findings. The ICR abstraction results were compared with the EQRO results using SAS®, and the concordance determined using the Kappa estimate. A weighted Kappa estimate of -0.09 for the Standard 9 reliability sample indicated substantial disagreement between the ICR and EQRO abstractors. The Kappa estimate of concordance was 0.5714 for the Standard 10 reliability sample, reflecting relatively strong agreement between the ICR and EQRO abstractors. Increasing the precision of the measure definitions and associated instructions to abstractors was recommended.

The behavioral health PIP included in the EQRO Annual Report was *Coordination of Care: Coordination of Behavioral Health and Acute Care Services*. The performance measure for this PIP, is the ICR Standard 10 measure, behavioral health care was coordinated with the member's PCP as required. The baseline data for adults and children were analyzed in the 2004 ICR Report, with 67% of adults and 81.5% of

children having their care coordinated as required by Standard 10. In year two (2), the PIP will stratify the adult population according to SMI or non-SMI. Subsequent years will compare CoC performance for all population groups, adult SMI, adult non-SMI, and child. The study question is whether educational efforts and a formalized process for the exchange of information between the Primary Care Physician and Behavioral Health Professional will result in better coordination of care as measured by the percent of behavioral health care recipients whose medical records contain evidence of coordination with the member's PCP as required.

An AHCCCS review team performed the Operational and Financial Review of the ADHS/DBHS PIHP for the period July 1, 2004 through June 30, 2005. One hundred six (106) standards were reviewed across seven (7) domains or program areas, including general administration, recipient services, delivery system, grievance and member rights, quality management and utilization management, finance, and encounters. AHCCCS received the required ADHS/DBHS corrective action plan (CAP) within 30 days of the CY 05 OFR transmittal, addressing each of 32 OFR recommendations.

In the CY 05 OFR review cycle, 91.5% of the 106 standards were rated as being in full or substantial compliance. Eighty-one percent of the 90 standards were rated as being in full or substantial compliance in CY 04, compared to 80% of the 77 standards in CY 03.

I. INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) is the single State agency for Arizona's Title XIX acute-care Medicaid program and the Title XXI State Children's Health Insurance Program. Arizona uses a behavioral health "carveout" model in which members receive general medical services through AHCCCS managed care health plans and receive covered behavioral health services through behavioral health managed care organizations. The behavioral health services are administered through a separate agency, the Arizona Department of Health Services (ADHS). The Division of Behavioral Health Services (DBHS), therefore, is within ADHS rather than within AHCCCS. The Division of Behavioral Health Services oversees the behavioral health services rendered for all state-supported programs, not just Medicaid, although Medicaid is the largest single category of eligible members for these services. The AHCCCS contract with ADHS/DBHS is considered by the federal Center for Medicare and Medicaid Services (CMS) as a Prepaid Independent Health Plan (PIHP).

The ADHS/DBHS has contracts with entities, known as Regional Behavioral Health Authorities (RBHAs), that are responsible for securing a network of providers, clinics, and other appropriate facilities and services to meet the behavioral health needs of eligible members within their contracted geographic service area (GSA). Maps illustrating Arizona GSAs and RBHAs are included as Appendices.

Each Medicaid member either chooses or is assigned to an acute care plan for his/her episodic and preventive health care needs. If the member requires behavioral health services, he/she is typically referred by that acute care plan to the appropriate RBHA, goes through an intake evaluation process, and then receives the care needed through the RBHA system. A Medicaid member may also self-refer directly to a RBHA or its contracted provider for behavioral health services.

In compliance with the Balanced Budget Act (BBA) of 1997, AHCCCS has included in its contract with ADHS/DBHS those elements that are required to monitor and measure quality of care. These are Performance Measures, Performance Improvement Projects, and an Operational and Financial Review (OFR) that monitors compliance with federal and state laws regarding managed care systems. The 1997 BBA also requires AHCCCS to submit an annual external quality review report to CMS. AHCCCS has contracted with HCE QualityQuest to produce the External Quality Review Organization (EQRO) Annual Report for behavioral health services.

II. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE MEASURE

COORDINATION OF CARE

A. Objectives

This external quality review study complies with the Centers for Medicare & Medicaid Services (CMS) protocol for *Validation of Performance Measures*.¹ It has the objective of identifying potential issues with the process and techniques used by ADHS/DBHS and their Independent Case Review (ICR) contractor in collecting, calculating, and reporting statewide performance measures for Coordination of Care. External quality review is required to be conducted in a manner *consistent with*, as compared to *identical to*, the CMS protocol.² Validation, in the context of the CMS protocol for performance measure validation, refers to determining whether a performance indicator actually measures what it purports to measure. One component of verifying whether the reported results of the performance measure are based on accurate source information, and/or are calculated appropriately, is to repeat the measurement on all or a sample of the data to determine the reliability (repeatability) of the findings. When different individuals or entities repeat calculations, the typical test to determine the comparability of the results is to examine the percentage agreement between the two sets of results. This is known as a test of the inter-rater reliability.

There were two Arizona Health Cost Care Containment System (AHCCCS) performance measures for Coordination of Care (CoC) for behavioral health care services, as reported by ADHS/DBHS through the 2004 Independent Case Review report submitted August 2005.³ The first CoC performance measure, known as Standard Nine (9), requires that the disposition of a referral from the Primary Care Provider (PCP) or Health Plan be communicated by the behavioral health provider to the PCP or Health Plan within 30 days of receiving the request for service. The second CoC performance measure, known as Standard 10, requires that behavioral health care be coordinated with the member's PCP as required. These are two of 18 standards pertaining to seven measures calculated and reported annually through the Independent Case Review process, which involves behavioral health clinical record abstraction from randomly selected samples of recipients of behavioral health services by geographic service area (GSA). ADHS/DBHS contracts with Regional Behavioral Health Authorities (RBHAs) who are responsible for administering delivery systems to eligible persons residing in the GSAs. ADHS/DBHS provides oversight of RBHA activities, in part, by tracking the measures subjected to Independent Case Review, as well as other measures, and establishing minimum thresholds, goals, and benchmarks for performance. The minimum threshold performance for each of the CoC measures was 60%, the goal was 75%, and the benchmark was 90%.4

The objective of this external quality review study was to determine the reliability of the ICR results for the two CoC measures at the statewide level.

B. Description of Data Collection Methodology

1. Independent Case Review Data Collection Methodology³

The 2004 ICR measured practice and clinical outcomes across GSAs, and provided a comparison between the 2003 and 2004 statewide results. The 2004 ICR study population included Title XIX and Title XXI enrolled adults and children in Arizona who received behavioral health services from April 1, 2004 through December 31, 2004. However, patient records were scanned to include all pertinent information from January 1, 2004 through December 31, 2004. The study population included only those members who were continuously enrolled as behavioral health recipients for at least 90 days during the six months prior to January 1, 2005. Members who received only transportation, laboratory, crisis, or radiology/medical imaging services were excluded from the study. A simple random sampling methodology was used to select the sample cases for the ICR study, based on a statewide pool of 80,515 RBHA-enrolled members, with samples of adults and children proportionate to the percent of the total number of behavioral health recipients in each GSA. This generated a total statewide sample size of 1,559 cases (1,070 adults and 489 children), which assured a 90% confidence level and a minimum error rate of 5% for each GSA, but not for each measure or standard. The number and percent of adults and children by RBHA are shown in Table 1.

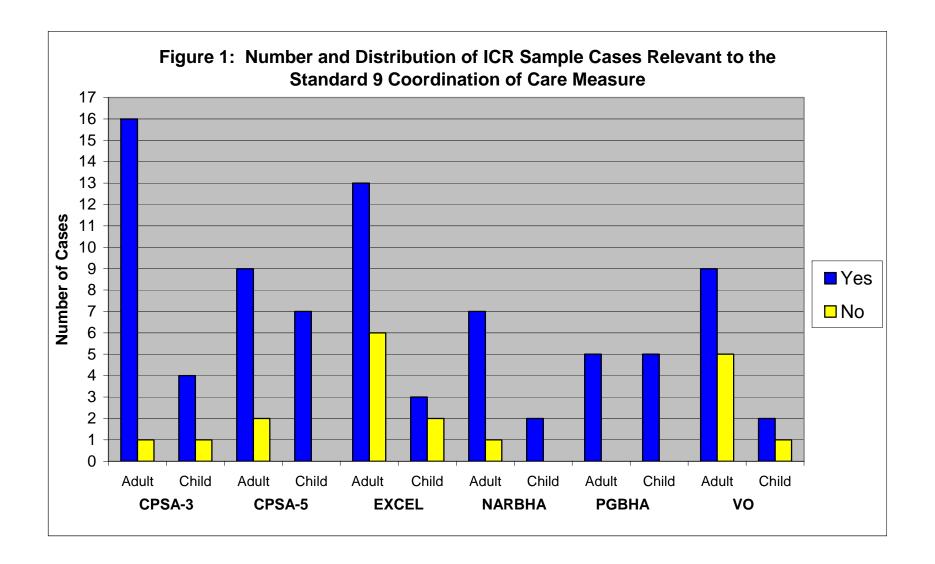
Table 1: Number and Percent of Population by RBHA

RBHA	Population	Number	Percent
CPSA-3	ADULT	174	11.16%
	CHILD	79	5.07%
CPSA-5	ADULT	183	11.74%
	CHILD	82	5.26%
EXCEL	ADULT	182	11.67%
	CHILD	69	4.43%
NARBHA	ADULT	188	12.06%
	CHILD	76	4.87%
PGBHA	ADULT	159	10.20%
	CHILD	97	6.22%
VO	ADULT	184	11.80%
	CHILD	86	5.52%

The ICR contractor worked with ADHS/DBHS to design an electronic behavioral health clinical record audit tool and associated scoring protocol, and coordinated with the RBHAs to obtain the behavioral health clinical records. The ICR contractor used a rater-to-standard method of monitoring the accuracy and reliability of the 12 reviewers. The data were analyzed using a scoring protocol that measured the

RBHA's performance on each of the 18 standards in the ICR tool. ADHS/DBHS established a minimum performance score for each of the standards. Each behavioral health record in the sample study population was evaluated according to each standard and rated "yes" as meeting the standard, "no" if the standard was not met, or "not applicable or N/A" if the standard did not apply to that member. For each standard, the denominator was the sum of all "yes" and "no" answers, and the numerator was the sum of all "yes" answers. Answers of "N/A" were excluded from the analysis of each standard. The exclusion of "N/A" responses meant that some standards contained small sample sizes.

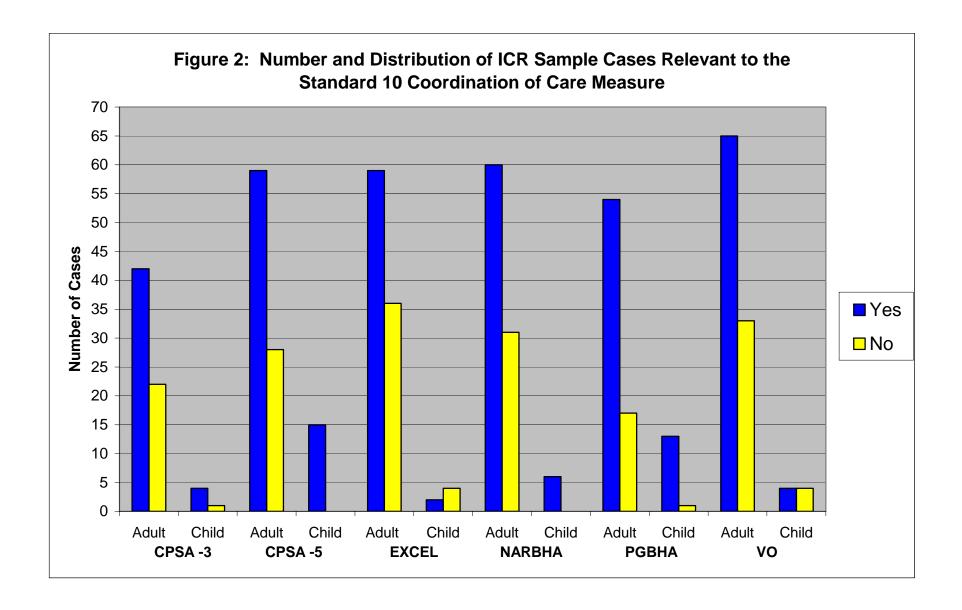
For CoC Standard 9, only 101 of the 1,559 ICR sample cases were recorded as having an answer of either "yes" or "no," with the remaining 1,458 scored as "N/A." Figure 1 displays the ICR distribution of these 101 cases.



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For 2004, the minimum acceptable performance score was 60% and the goal was 75% for CoC Standard 9, "the disposition of the referral from the PCP or Health Plan is communicated by the behavioral health provider to the PCP or Health Plan within 30 days of receiving the request for service." The 2004 ICR results showed that the statewide performance for CoC Standard 9 was 79.7% for adults and 85.2% for children, exceeding the goal for each of the two age groups.

For CoC Standard 10, 560 of the 1,559 ICR sample cases were recorded as having an answer of either "yes" or "no," with the remaining 999 scored as "N/A." Figure 2 displays the ICR distribution of these 560 cases.



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For 2004, the minimum acceptable performance score was 60% and the goal was 75% for Coordination of Care Standard 10, "behavioral health care has been coordinated with the member's PCP as required." The 2004 ICR results found that the statewide performance for CoC Standard 10 was 67% for adults and 81.5% for children, meeting the minimum threshold performance expectation for adults and exceeding the goal for children.

2. EQRO Data Collection Methodology

A computer disc was received from ADHS/DBHS through AHCCCS that contained six Microsoft Excel files, each representing the ICR abstraction results across all 18 standards for the ICR sample of adults and children served by each RBHA. The ICR findings for the two CoC measures, Standards 9 and 10, were isolated and analyzed. Given that 94% of the ICR sample was rated as "N/A" for Standard 9, and 64% was rated as "N/A" for Standard 10, the decision was made, in consultation with AHCCCS, to re-abstract a reliability sample of 30 for Standard 9 from the 101 cases rated "yes" or "no" in the ICR study. Similarly, a reliability sample of 30 was reabstracted for Standard 10 from the 560 cases rated "yes" or "no" in the ICR sample. These reliability sample sizes allow a comparison of the results at the statewide level, but are not large enough to make comparisons at the RBHA level. All confidence levels and margins of error or confidence intervals were calculated online using the sample size calculator.⁵ Based on the ICR population of 101 for Standard 9, the validation sample of 30 provided a 90% confidence level and a 12.65% margin of error.⁵ Given the ICR population of 560 for Standard 10, the validation sample of 30 provided a confidence level of 90% and a 14.62% margin of error.⁵

A 20% over-sample of 6 cases for each of the two CoC EQRO samples was drawn to assure the availability of 30 charts to abstract. The 101 ICR cases with a "yes" or "no" for Standard 9 were alphabetized by RBHA and, using SAS®, a simple random sampling procedure was used to select 36 cases for Standard 9. Similarly, 36 cases were selected from the 560 ICR cases with a "yes" or "no" for Standard 10. There was no stratification by RBHA in the EQRO sampling process. These two lists of EQRO sample cases were sent to AHCCCS, and the associated behavioral health records were obtained from ADHS/DBHS. Computer files of the scanned medical records were received for five of the RBHAs, and paper copies for the sixth. As all 36 records were received for each of the EQRO samples, every fifth record was selected without replacement until 30 of the 36 records were chosen for abstraction. This procedure was followed to produce the reliability samples for Standard 9 and for Standard 10.

C. Validation of Measure

The reliability of the two CoC performance measures was measured by randomly selecting the two samples as described above, re-abstracting the records using the applicable portion of the ICR abstraction tool and ICR abstraction instructions, and comparing the ICR and EQRO results.

The ICR abstraction tool description for Standards 9 and 10 was as follows.³

• 9) The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.

Yes No N/A

• 10) Behavioral health care has been coordinated with the member's PCP as required. Yes No N/A

The ICR instructions to behavioral health record abstractors were as follows for Standards 9 and 10.³

- Standard 9. "Review the documentation for a verbal referral or a hard copy referral from the PCP/Health Plan regarding behavioral health needs for an individual. If there is not a request, answer N/A. Answer YES if documentation is located indicating the behavioral health provider has communicated to the PCP/health plan regarding the disposition of the referral within 30 days of the request for service. Answer NO if there was a request and documentation is not located or if the disposition was dated greater than 30 days after the request for referral. If a disposition is located without a request or referral date, answer N/A."
- Standard 10. "Review the documentation and determine if behavioral health care information had been coordinated/communicated with the individual's PCP as required. Relevant behavioral health information must be communicated to the PCP for all Title XIX/XXI individuals who meet one of the criteria listed below:
 - 1. Been referred by the PCP/Health Plan OR
 - 2. Determined to have a serious mental illness OR
 - 3. Upon request of the PCP

At a minimum, the individual's diagnosis and current prescribed medications (including strength and dosage) must be provided to the individual's assigned PCP. Answer YES if the required or requested coordination of care documentation is present and answer NO if there is no documentation of communication with the PCP. If the individual is in a category in which communication to the PCP or health plan is not mandatory, answer N/A."

Two experienced external quality review medical record abstractors were provided with the abstraction tool and instructions for Standards 9, and 10 and given two of the medical records from each of the two reliability samples to use for training purposes to assure inter-rater reliability. Each abstractor independently reviewed the two medical records used for training purposes without advanced discussion. Each abstractor scored the two "test" records identically and, therefore, these two cases were used in the results. One abstractor scored the 30 records for Standard 9, and the other abstracted the 30 records for Standard 10.

Several problems of interpretation arose during external quality review re-abstraction that required consultation with the Director of Review Services. For example, three Standard 9 cases were rated "N/A" during external review; identification of the referral could not be found for two of these, and the third was listed as being self-referred, although there was some coordination later with a PCP. The major problem encountered for Standard 10 was that it is unclear from the ICR instructions how to score a situation where there was some communication with the PCP or Health Plan, but not all the required information was communicated. For example, the instructions state, "At a minimum, the individual's diagnosis and current prescribed medications (including strength and dosage) must be provided to the individual's assigned PCP. Answer YES if the required or requested coordination of care documentation is present, and answer NO if there is no documentation of communication with the PCP." The question remains, however, how to answer if SOME communication is documented but not ALL the minimum information was transmitted? For example, what if the diagnosis was communicated but not the prescribed medications? Or what if the prescribed medication strength was communicated but not the dosage? It is possible that the ICR and EQRO abstractors scored such cases differently.

Using SAS®, the ICR abstraction results were compared with the EQRO results for each of the 30 individuals in each of the external quality review samples, and the concordance was determined using the Kappa estimate. Viera and Garrett⁶ describe the Kappa estimate as "intended to give the reader a quantitative measure of the magnitude of agreement between observers." They add, "The calculation is based on the difference between how much agreement is actually present ('observed' agreement) compared to how much agreement would be expected to be present by chance alone ('expected' agreement)." Kappa lies on a scale from -1 to +1, with -1 representing systematic disagreement between observers, 0 representing what would be expected by chance alone, and +1 representing perfect agreement.

The EQRO abstractor coded three (3) of the 30 Standard 9 sample cases as N/A, whereas zero (0) of these three were coded N/A by the ICR abstractors, necessitating that statistical correction factors be employed. The concordance analysis of the abstraction results for the 30 cases in the Standard 9 reliability sample resulted in a weighted Kappa⁷ estimate of –0.09, indicating that there was substantial disagreement between the ICR and EQRO raters. This is attributable to the EQRO abstractor coding three cases as N/A, while the ICR abstractors coded each of the cases as either "yes" or "no." Additionally, the EQRO abstractor coded zero (0) cases as "no," while the ICR abstractors coded four (4) cases as "no." The distribution of responses for Standard 9 by rater and response is displayed in Table 2.

Table 2: Concordance of Review for CoC Standard 9

EQRO

,		Yes	No	N/A	Total
	Yes	23	0	3	26
ICR	No	4	0	0	4
	N/A	0	0	0	0
	Total	27	0	3	30

Table 2 shows, for the EQRO reliability sample for CoC Standard 9, that the EQRO rated 27 of the cases as "yes," zero (0) as "no," and three (3) as N/A. The ICR results when these same cases were reviewed were 26 as "yes," four (4) as "no," and zero (0) as N/A. The cases where there was concordance for how a given case was rated by the ICR and the EQRO are displayed in the cells on the diagonal of Table 2. Thus, the ICR and EQRO were in agreement on 23 of the 30 cases, each of which was rated "yes." Therefore, the ICR and EQRO abstractors were in concordance that, for 76.6% of the cases, that the disposition of the referral from the PCP or Health Plan was communicated by the behavioral health provider to the PCP or Health Plan within 30 days of receiving the request for service. This level of performance met the goal for this CoC measure.

For the EQRO reliability sample for Standard 10, all EQRO and ICR abstractors coded either "yes" or "no" for each of the 30 cases. There were no N/A responses, so the correction factor described in the SAS® documentation for computing agreement statistics did not have to be used. The concordance for ICR and EQRO review responses is displayed in Table 3. The Kappa estimate of concordance is 0.5714, reflecting relatively strong agreement between the ICR and EQRO abstractors.

Table 3: Concordance of Review for CoC Standard 10

EQRO

		Yes	No	Total
ICR	Yes	16	2	18
	No	4	8	12
	Total	20	10	30

Table 3 shows, for the EQRO reliability sample for CoC Standard 10, that the EQRO rated 20 of the 30 cases as "yes" and 10 as "no." The ICR results when these same cases

were reviewed were 18 as "yes" and 12 as "no." The cases where there was concordance and shown in the cells on the diagonal of Table 3. The ICR and EQRO raters were in agreement on 24 of the 30 cases, 16 of which were rated as "yes" and 8 as "no." Thus, the statewide performance for the Standard 10 CoC measure was not as strong as for the Standard 9 CoC measure, even though the concordance of results between the ICR and EQRO abstractors was better for Standard 10.

D. Assessment of Strengths and Weaknesses

The practice by AHCCCS of setting standards for performance measures and incorporating these standards in the contract with ADHS/DBHS is a significant strength in terms of establishing expectations and stimulating the achievement of measurement goals and benchmarks.

One weakness was the scoring discrepancies found when comparing the ICR results and EQRO results for the reliability studies of each of the two CoC performance measures, both Standard 9 and Standard 10.

The CY 05 ICR found high levels of CoC, as did the EQRO performance measure validation, although performance on neither of the CoC measures reached benchmark levels. EQRO reliability testing confirmed, however, that the goal was met for statewide performance on Standard 9, communicating the disposition within 30 days of receipt of a referral. Statewide performance on the Standard 10 CoC measure was not as strong as for Standard 9. Nevertheless, the EQRO reliability testing confirmed that the minimum threshold performance was met or exceeded statewide for behavioral health care coordination as required by Standard 10.

E. Conclusions

The statewide performance for each of the two CoC measures, as reported by the ICR for CY 05, exceeded the minimum threshold of 60% for both adults and children, and exceeded the goal of 75% for children across both measures. Coordinating behavioral health care as required with the member's PCP was substantially improved in CY 05 for both adults and children compared to the previous two years, as displayed in Table 4. Communicating the disposition of a referral was somewhat improved compared to earlier years.

Table 4: Performance on Coordination of Care Indicators or Measured Through Independent Medical Record Review

Standard	Population	CY 03 Performance	CY 04 Performance	CY 05 Performance
Disposition of a referral from the PCP/Health Plan within 30 days	Adults	69.0%	75.4%	79.7%
of receiving the request for service	Children	78.6%	71.1%	85.2%
Behavioral healthcare coordinated with the member's PCP as	Adults	52.4%	50.6%	67.0%
required	Children	56.2%	47.8%	81.5%

AHCCCS and ADHS/DBHS have made CoC a priority, and a performance improvement project has been designed to focus on coordination activities for individuals with the greatest needs. A Collaborative Agreement Task Force has also been developed to propose solutions to improve the CoC between acute medical and behavioral health systems.

F. Recommendations

Increasing the precision of the definitions of the measures and associated instructions to abstractors might improve the extent of agreement when the records are abstracted and subsequently re-abstracted for reliability testing purposes. Consideration might also be given to adding additional ways to score when "some" coordination takes place, but not all the "minimum" requirements are met, or to record the number of days it takes for the disposition of a referral to be communicated, so as to better understand the extent of coordination. It is also important to assure that the pages of the behavioral health record used for the ICR study are identical to those used for re-abstraction purposes in testing reliability.

References

- ^{1.} Department of Health and Human Services, Centers for Medicare & Medicaid Services, <u>Validating Performance Measures</u>, <u>A Protocol for Use in Conducting Medicaid External Quality Review Activities</u>, (Final Protocol, Version 1.0), May 1, 2002
- ² Department of Health and Human Services, <u>Final Rule on External Quality</u>
 <u>Review of Medicaid Managed Care Organizations</u>, (Federal Register), January 24,
 2003
 - ^{3.} ADHS Independent Case Review, August 2005
- ^{4.} <u>ADHS/DBHS Quality Management/Utilization Management Annual Plan</u> 2004-2005, October 1, 2005 – September 30, 2006
 - 5. Sample Size Calculator Online: http://raosoft.com/samplesize.html
- ^{6.} Viera, A.J., MD and Garrett, J.M., PhD. <u>Understanding Interobserver</u>

 <u>Agreement: The Kappa Statistic</u>. Family Medicine. May 2005, p. 360-363
 - ^{7.} <u>Technical FAQ (1518)</u>. Support.SAS.com Documentation.

 $\underline{http://support.sas.com/faq/015/FAQ01518.html}$

III. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE IMPROVEMENT PROJECT

COORDINATION OF CARE: COORDINATION OF BEHAVIORAL HEALTH AND ACUTE CARE SYSTEMS

A. Objectives

The Behavioral Health Performance Improvement Project (PIP) for external quality review in CY 05 was *Coordination of Care: Coordination of Behavioral Health and Acute Care Systems*. The performance measure for this PIP is the Standard 10 Independent Case Review (ICR) measure that requires behavioral health care to be coordinated with the member's Primary Care Physician (PCP) as required.

Chapter 900 of the AHCCCS Medical Policy Manual defines a PIP as "a planned process of data gathering, evaluation, and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery." Chapter 900, Policy 980, contains selection and assessment criteria for PIPs, and Policy 990 governs PIP reporting requirements. ¹

PIPs are expected to improve the quality of care and service delivery, and a PIP plan must include the following.²

- Identifying areas for improvement
- Gathering baseline data from administrative data and other sources
- Designing and implementing intervention(s)
- Measuring the impact of the intervention(s)
- Sustaining that improvement

If performance improves as a result of the intervention(s), the minimum duration of a PIP will be four years. AHCCCS has established the following timeframes for PIPs.²

- The first year is when baseline measurement data are submitted
- The second year is the intervention year, and no report is due
- The third year is the re-measurement period that will demonstrate if performance has improved since baseline
- The fourth year is another re-measurement year to determine the sustainability of the results of performance improvement interventions

The Coordination of Care PIP study question is whether educational efforts and a formalized process for the exchange of information between the Primary Care Physician and Behavioral Health Professional will result in better coordination of care as measured by the percent of behavioral health care recipients whose medical records contain evidence of coordination with the member's PCP as required.³

Four goals were specified in the ADHS/DBHS PIP Proposal for Coordination of Behavioral Health and Acute Care Systems.³

- 1. To identify best practices for coordinating behavioral and acute health care and apply such practices to persons determined to have a serious mental illness
- 2. To develop and implement a method/process for exchanging information between systems that is efficient, timely, and effective in improving coordination of care
- 3. To use lessons learned from targeting coordination of care activities for those individuals determined to have a serious mental illness and apply processes to other populations enrolled in the behavioral health system
- 4. To meet the AHCCCS/ADHS performance measure goal of 75% for coordination of care

Implementation was proposed to begin December 1, 2005, and the PIP contains two phases.³ Phase I is expected to focus on coordination of care for individuals with serious mental illness (SMI) and on planning for Phase II. The focus of Phase II will be coordination of care for all individuals with behavioral health care needs (adult SMI, adult non-SMI, and child). Lessons learned in Phase I will be used in Phase II, including best practices and interventions.

The first year of project implementation will focus on forming the project team, developing an action plan, reviewing proposed interventions and project indicators, identifying implementation barriers, developing the data collection methodology, and establishing baseline data for the adult and child population based on the results of the 2004 ICR. The frequency of coordination of care will be estimated during the first year. The second year will focus on stratifying the baseline data by adult SMI, adult non-SMI, and child based on the results of the 2005 ICR. Year two will also be used for evaluating the efficiency of the data collection procedure and implementation of interventions. Year three will focus on assessing the adequacy and effectiveness of the measurement tool and determining the effectiveness of the interventions implemented. Subsequent years will involve re-measurement to determine if improvements made as a result of the interventions are being sustained for both SMI and non-SMI populations.

The following were proposed as PIP interventions.³

- Develop a secure electronic system to exchange critical information between the Primary Care Physician and Behavioral Health Professional such as current diagnosis, medications, current PCP, lab reports/updates, and a complete history and physical, including family history
- Develop and establish a rapid and timely reporting process

B. Description of Data Collection Methodology

During the first year of Phase I, PIP data were analyzed for Adult and Child populations only through the 2004 ICR process. The study population for Phase I, Year 2, includes all Title XIX and Title XXI eligible adult SMI and adult non-SMI populations who are enrolled in the Arizona behavioral health system and whose records contain evidence of the need for coordination of care with their PCP. The study population for Phase II will have the addition of children to the populations included in Phase I.

Basic demographic data for the samples will be extracted from the ADHS CIS Enrollment Table, including client name, date of birth, intake date, and behavioral health category. Study population inclusion criteria require that the following criteria be met.

- The person was enrolled as a Title XIX /XXI member during the study period
- The person received a behavioral health service during the study period other than laboratory/radiology, transportation, or crisis
- The person was continuously enrolled for at least 90 days during the 6 months prior to implementation of the case review

A random sampling methodology will be employed, based on statewide enrollment numbers, selecting a representative sample proportional to the number of children and adults for each GSA. The sample size will be sufficient to assure a 90% confidence level and minimum error rate of five (5) percent for each GSA. An over-sample will be selected for each GSA, and these cases will be used to replace any records from the original sample that meet the exclusion criteria.

C. Description of Data

The ADHS/DBHS Coordination of Care (CoC) PIP proposal does not specifically define the performance measure(s).³ According to AHCCCS, the measure is the same as the Standard 10 CoC measure of behavioral health care being coordinated with the member's PCP as required (See II-7).

Data are collected and analyzed annually through an ADHS/DBHS-awarded contract for performing Independent Case Review on a number of measures, including the CoC measure. Both AHCCCS and ADHS/DBHS played a role in the ICR process. AHCCCS approved the ICR methodology and process for this measure. This was the situation for the CoC PIP measure in the 2004 ICR, where 560 of the 1,559 ICR sample cases were applicable to the Standard 10 CoC measure.

The 2004 ICR report for CY 05 found that behavioral health care was coordinated with the member's PCP as required for 67% of the adults in the sample and 81.5% for the children. This met the minimum threshold performance for adults and exceeded the goal for children.

To examine the 2004 ICR findings based on SMI status, the EQRO analyzed the ICR abstraction results for the Standard 10 CoC measure, stratified according to SMI status, as shown in Table 1.

Table 1: 2004 ICR Results for Standard 10 CoC Stratified by SMI Status

RBHA	Population	Total Number of Cases	Number Where Care was Coordinated	Percent Where Care was Coordinated
CPSA-3	Adult non-SMI	23	17	73.91%
	Adult SMI	41	25	60.98%
	Child	5	4	80.00%
CPSA-5	Adult non-SMI	14	14	100.00%
	Adult SMI	73	45	61.64%
	Child	15	15	100.00%
EXCEL	Adult non-SMI	25	20	80.00%
	Adult SMI	70	39	55.71%
	Child	6	2	33.33%
NARBHA	Adult non-SMI	16	10	62.50%
	Adult SMI	75	50	66.67%
	Child	6	6	100.00%
PGBHA	Adult non-SMI	17	14	82.35%
	Adult SMI	54	40	74.07%
	Child	14	13	92.86%
VO	Adult non-SMI	18	15	83.33%
	Adult SMI	80	50	62.50%
	Child	8	4	50.00%

For five (5) of the six (6) RBHAs, a lower percentage of the SMI adults had their care properly coordinated with their PCP compared to the non-SMI adults. This is added evidence of the need for the CoC PIP. In 5 of the 6 cases, the Standard 10 CoC measure for SMI adults met or exceeded the minimum threshold performance of 60%, with one RBHA not achieving the minimum expectation. For only one RBHA did the CoC performance for SMI adults nearly reach the goal of 75%.

D. Review of Analysis Methodology

During the first year of Phase I, data were collected for the adult and child populations only and analyzed during the 2004 ICR process. The SMI and non-SMI data will be collected starting with the 2005 ICR. The PIP measure will be analyzed and reported annually, categorized by RBHA and population groups as follows.

 Number and percent of adult SMI members whose medical records contain documentation of adequate and timely coordination of care with the PCP

Numerator: Number of adult SMI member records that contain documentation of adequate/timely coordination of care with the PCP

Denominator: Number of adult SMI member records that contain documentation of adequate/timely coordination of care with the PCP, and number of adult SMI member records that contain inadequate coordination of care with the PCP

Number and percent of adult non-SMI members whose medical records contain documentation of adequate and timely coordination of care with the PCP

Numerator: Number of adult non-SMI member records that contain documentation of adequate coordination of care with the PCP

Denominator: Number of adult non-SMI member records that contain documentation of adequate coordination of care with the PCP, and number of adult non-SMI member records that contain inadequate coordination of care with the PCP

 Number and percent of child members whose medical records contain documentation of adequate and timely coordination of care

Numerator: Number of child member records that contain documentation of adequate coordination of care with the PCP

Denominator: Number of child member records that contain documentation of adequate coordination of care with the PCP, and number of child member records that contain inadequate coordination of care with the PCP

The ICR independent contractor performs chart reviews according to a pre-determined protocol. The reviewers are numerous behavioral health professionals chosen from various fields and trained to abstract behavioral health records. Initially each of the abstractors will review a sub-sample of behavioral health records, and the results will be tabulated and compared to determine inter-rater reliability. Abstractors must meet a minimum threshold performance prior to field abstraction. Additionally, a rater-to-standard method of monitoring the reliability and accuracy of the abstractors will be conducted on an ongoing basis.

Data analysis will include comparison of RBHA performance across time, comparison against a statewide average, and comparison with the performance standards in the AHCCCS/ADHS contract. The CY 05 Minimum Performance Standard was 60%, the CY 05 Goal was 75%, and the CY 05 Benchmark was 90%. These performance standards remained the same in the CY 06 AHCCCS/ADHS contract. The target time frame to reach the goal of 75% for the CoC measure is the end of the second year of PIP implementation. There will be four annual measurement periods.

E. Assessment of Strengths and Weaknesses Related to Quality of Care, Timeliness, and Access

The CoC PIP is more relevant to quality of care than to timeliness or access. Populations covered by Medicaid have been found to have higher levels of co-occurring physical and behavioral health problems than other estimates available for the general population.⁴

The Institute of Medicine's report, *Crossing the Quality Chasm*, included the development of effective teams as a recommendation for how to improve health care quality.⁵ Two major recommendations in the *Quality Chasm* report involve coordination. One is that, "Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care." The second recommendation calls for, "Better coordination of care among services and settings, both within and among organizations...."

A strength of the ADHS/DBHS CoC PIP is that it formalizes the expectation of coordination between behavioral health care providers and PCPs, and measures and publicly reports the extent of this collaboration over time. A further strength is the ADHS/DBHS sample communications form, Provider Manual Form 4.3.1, that outlines the required elements for behavioral health providers to coordinate with AHCCCS acute-care health plan PCPs.⁶

The BBA of 1997 and its associated protocol for PIP validation specify the following 10 tasks for assessing the MCO/PIHP's methodology for conduction the PIP.

- Reviewing the selected study topic
- Reviewing the study question
- Reviewing the selected study indicator(s)
- Reviewing the identified study population
- Reviewing sampling methods
- Reviewing the data collection procedures
- Assessing the improvement strategies
- Reviewing data analysis and interpretation of study results
- Assessing the likelihood that reported improvement is "real" improvement
- Assessing whether the MCO/PIHP has sustained documented improvement

There are several opportunities for methodological and systemic improvement in the CoC PIP design and implementation. In particular, the selected study indicator(s) are not clearly and unambiguously defined in the PIP plan. The medical record abstraction tool should be reviewed to ensure that data related to the measure will be meaningfully and reliably captured. The range of responses allowed during record abstraction should be reviewed and possibly expanded. Instructions to abstractors should be evaluated for clarity and specificity, including inclusion and exclusion criteria. For example, the defining variables for SMI status should be specified in the abstraction instructions. If the study indicator(s) or number/range of possible abstraction responses or abstraction

instructions are substantially changed, consideration should be given to the possibility of a new baseline year after these improvements are made.

A new baseline year should also be considered if sampling methods are significantly changed, as is recommended. Sample sizes should allow an acceptable confidence level and margin or error for each measure statewide, as well as for each age group or other stratification level such as SMI status. Sample sizes large enough to allow a 95% confidence level and five (5) percent margin of error are recommended.

F. Conclusions

In their collaboration agreement, AHCCCS and ADHS/DBHS have identified coordination, communication, and information-sharing challenges between the Arizona behavioral health and acute care systems. Because any lack of efficient and effective communication may have resulted in the absence of coordinated treatment and poor care outcomes for patients with combined behavioral and medical problems, AHCCCS and ADHS/DBHS have made coordination of care a priority, not only through this PIP but through convening a Collaborative Agreement Task Force focusing on these issues.

The ICR process is one of the routine methods AHCCCS uses to assess ADHS/DBHS performance. Independent Case Review involves the annual analysis and reporting of several measures, one of which is the coordination of care between behavioral health professionals and acute care primary care providers. The historical analysis and reporting of the PIP CoC performance measure through the ICR process are strengths. A potential problem, however, is that the sample selection process used for ICR allows for acceptable overall confidence intervals at the GSA or RBHA level, but not for each of the measures. Only 560 of the 1,559 cases in the 2004 ICR sample were relevant to the Standard 10 CoC measure, presumed to be the performance measure for this PIP.

The 2004 ICR report for CY 05 found that behavioral health care was coordinated with the member's PCP as required for 67% of the adults in the sample, which is just above the minimum threshold for this measure. Subsequent EQRO analysis of the ICR data suggests that coordination may, in many instances, not occur as frequently for the adult SMI population as for adults who are not seriously mentally ill. Thus the AHCCCS and ADHS/DBHS focus on improving coordination for the SMI population, as well as improving coordination with acute-care medical system for all behavioral health care recipients, is important and timely.

G. Recommendations

The CoC PIP would be strengthened by having its own sample selection to assure the desired stratification and confidence levels. Additionally, the wording of the CoC measure is very general, and the requirements reviewed for compliance with the measure are limited in scope. There are opportunities for improvement in better definition of the measure, the inclusion and exclusion requirements, and the instructions to the record abstractors. Consideration should also be given to providing a broader continuum of

assessment, rather than a "yes" or "no" decision, as "some" coordination may occur but not "all" the desired elements. Improvements in the measurement process would greatly benefit this PIP. However, changes in the measure, or sample selection, or abstraction processes would, optimally, suggest having a new baseline year against which to assess the improvements from any interventions. Consistency in measurement across PIP timelines is a basic tenet, with the advantage that interpretation of changes/improvement can be made much more reliably.

References

¹AHCCCS, <u>Medical Policy Manual, Chapter 900, Quality Management and Performance Improvement Program</u>

²AHCCCS, Quality Assessment and Performance Improvement Strategy, October 2005

³ADHS/DBHS, <u>Performance Improvement Project Proposal, Coordination of Behavioral Health and Acute Care Systems</u>, FY 2006, Revised 12/9/05

⁴Heflinger, C.A. and Saunders, R.C. <u>Physical and Behavioral Health of Medicaid</u>
Children in Two Southern States. Southern Medical Journal. 98(4): 429-435, April 2005

⁵Institute of Medicine, <u>Crossing the Quality Chasm: A New Health System for</u> the Twenty-first Century. Washington: National Academy Press, 2001

⁶ADHS/DBHS Provider Manual, Section 4.3: Coordination of Care with AHCCCS Health Plans and Primary Care Providers, 9/03/2004 Revision, Effective 10/15/2004

IV. REVIEW, ANALYSIS, AND SUMMARY OF AHCCCS COMPLIANCE WITH MEDICAID MANAGED CARE FEDERAL AND STATE REGULATIONS

A. Objectives

An annual Operational and Financial Review (OFR) is used by AHCCCS to monitor and evaluate ADHS/DBHS compliance with Medicaid managed care federal and state regulations pertaining to behavioral health services. The CY 05 OFR, for the contract period July 1, 2004 through June 30, 2005, was conducted by AHCCCS from November 4 through November 18, 2005. AHCCCS transmitted the final CY 05 OFR report to ADHS/DBHS on March 6, 2006. The ADHS/DBHS corrective action plan (CAP) required to address the OFR recommendations was submitted to AHCCCS on April 5, 2006.

To ensure ADHS/DBHS' operational and financial program compliance with its contract with AHCCCS, the AHCCCS OFR review team's activities were as follows.¹

- Determining if ADHS/DBHS satisfactorily met AHCCCS requirements as specified in contract, policy, and rule
- Reviewing the progress made toward implementing the recommendations made during the previous review
- Reviewing outcomes of interventions for performance measures and performance improvement projects
- Reviewing records of appeals for timeliness and appropriateness
- Determining if ADHS/DBHS was in compliance with its policies and procedures, and evaluating the effectiveness of those policies and procedures
- Providing technical assistance and identifying areas in which improvements could be made, as well as identifying areas of noteworthy performance and accomplishment
- Conducting interviews or group conferences with members of ADHS/DBHS' administrative staff.
- Examining records, books, reports, and information systems of ADHS/DBHS or other contractor or management company as necessary

The OFR process used by AHCCCS is consistent with the required protocol for Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs),² as required by the CMS Final Rule on External Quality Review (EQR) of Medicaid Managed Care Organizations.³

B. Description of Data and Information Collection Methodology

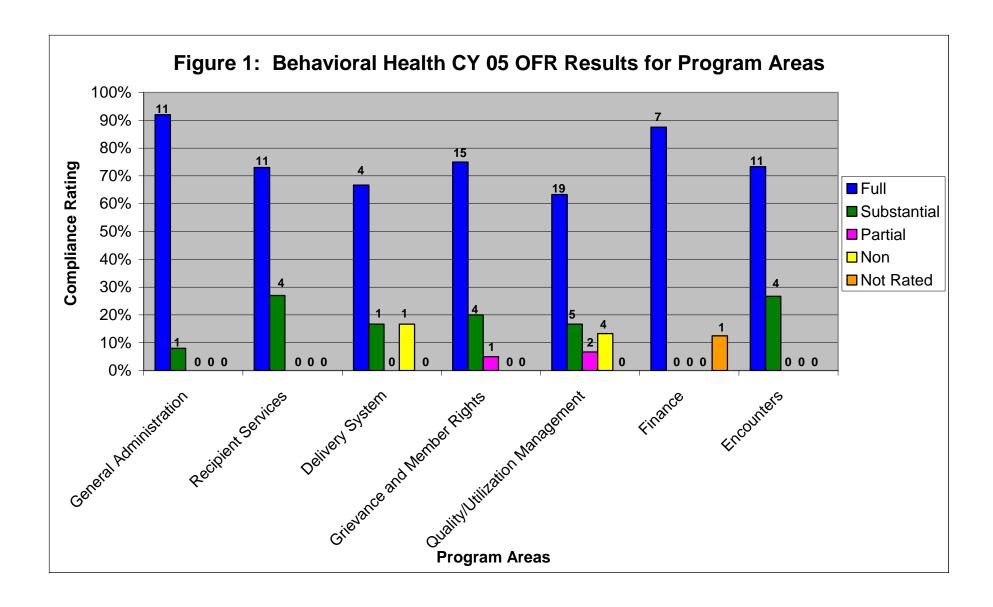
The 16-member AHCCCS OFR review team was made up of staff from Acute Care Operations, the Office of Legal Assistance, the Division of Health Care Management, Third Party Liability, and the Office of Program Integrity. Twenty one (21) staff from ADHS/DBHS participated in the review. The OFR tool contained 106 standards and substandards from seven (7) domains or program areas. The program areas included general administration, recipient services, delivery system, grievance and member rights, quality management/utilization management, finance, and encounters. Findings were documented for each standard/substandard and a compliance rating assigned. AHCCCS required ADHS/DBHS to develop a corrective action plan (CAP) for all standard/substandard(s) where there were recommendations that some action must or should be taken. The CAP was due to AHCCCS for approval within 30 days of the final OFR report.

C. Description of Data and Information

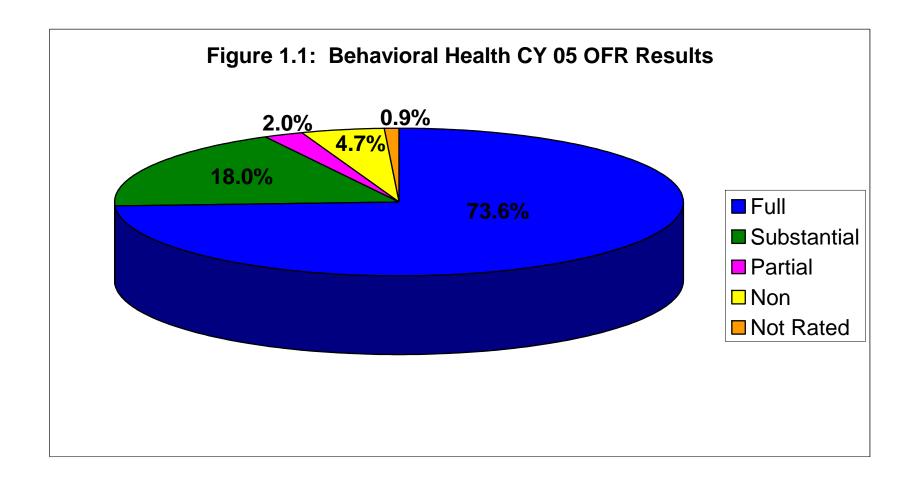
Table 1, Figure 1, and Figure 1.1 illustrate the results of the behavioral health CY 05 OFR across the seven (7) program areas reviewed.

Table 1: Behavioral Health CY 05 OFR Results

Table 1. Behavioral Health 61 66 61 K Recards						
	Total					
	Number of					
Program Areas	Standards	Compliance Rating for Standard				
		Full	Substantial	Partial	Non	Not Rated
		(11)	(1)	(0)	(0)	(0)
General Administration	12	92%	8%	0%	0%	0%
		(11)	(4)	(0)	(0)	(0)
Recipient Services	15	73%	27%	0%	0%	0%
		(4)	(1)	(0)	(1)	(0)
Delivery System	6	66.7%	16.7%	0%	16.7%	0%
		(15)	(4)	(1)	(0)	(0)
Grievance and Member Rights	20	75%	20%	5%	0%	0%
		(19)	(5)	(2)	(4)	(0)
Quality/Utilization Management	30	63.3%	16.7%	6.7%	13.3%	0%
		(7)	(0)	(0)	(0)	(1)
Finance	8	87.5%	0%	0%	0%	12.5%
		(11)	(4)	(0)	(0)	(0)
Encounters	15	73.3%	26.7%	0%	0%	0%
		(78)	(19)	(3)	(5)	(1)
Total	106	73.6%	18%	2.8%	4.7%	0.9%



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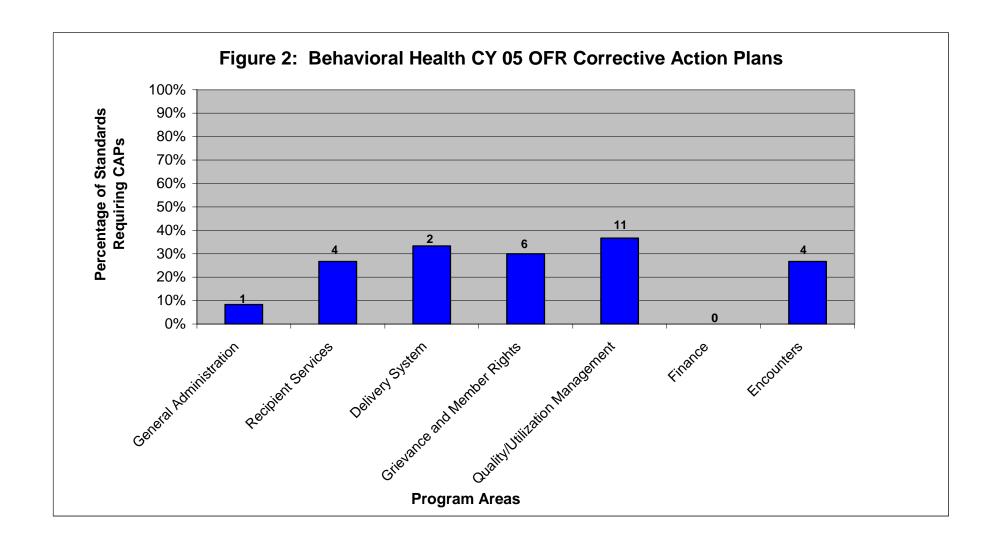
June 7, 2006 IV-4

As shown in Figures 1 and 1.1, ADHS/DBHS was rated in full or substantial compliance in CY 05 for 97 of the 106 standards, or 91.5%. ADHS/DBHS was rated as being in partial compliance for three (3) standards, non-compliant for five (5), and one (1) was not rated.

The number of standards and/or sub-standards requiring corrective action plans is illustrated in Table 2 across the seven OFR program areas, and the percentages are graphically presented in Figure 2.

Table 2: Behavioral Health CY 05 OFR Corrective Action Plans

Program Areas	Total Number of Standards	Number of Recommendations Requiring CAPs	Number of Standards Requiring	Percentage of Standards Requiring
			CAPs	CAPs
General Administration	12	1	1	8.3%
Recipient Services	15	5	4	26.7%
Delivery System	6	2	2	33.3%
Grievance and Member Rights	20	6	6	30.0%
Quality/Utilization Management	30	14	11	36.7%
Finance	8	0	0	0.0%
Encounters	15	4	4	26.7%
Total	106	32	28	26.4%



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The CY 05 OFR included the following recommendation requiring corrective action plans from ADHS/DBHS.⁴

1. Recipient Services

- Evidence an achievement of the statewide contractual performance standard of 80% to ensure that behavioral health recipient/family cultural preferences are assessed and included in treatment by behavioral health providers
- Educate employees about how to obtain interpretation services for behavioral health recipients
- Monitor to determine that contractors have educated their employees about how to obtain interpretation services for behavioral health recipients
- Monitor to determine that contractors' employees have access to references listing resources for behavioral health recipients with diverse cultural needs
- Evidence achievement of the statewide contractual performance standard of 80% when monitoring to ensure that behavioral health recipients and/or parents/guardians are informed about and give consent for prescribed medications

2. Delivery System

- Maintain a provider network that is sufficient to provide all covered services to AHCCCS members, including prescribing clinicians in all areas
- Monitor to determine that contractors and subcontractors provide second opinions as required

3. Grievance System

- Assure that any appeal extension taken does not exceed 14 days
- Document appeal extensions
- Document extensions for all matters
- Indicate the legal basis for all Notice of Decisions
- Implement a policy that requires RBHAs to track, trend, and analyze claim disputes for potential fraud

4. Quality Management/Utilization Management

- Continue to take actions necessary to ensure the receipt of timely and complete encounter data in order to fulfill the requirements of the contract and to enable complete calculation of encounter-based performance measures
- Systematically and consistently analyze grievance, appeal, expedited appeal, mortality, and incident/accident data as part of the quality

- management process; use the resultant data analyses to inform clinical and administrative decisions and to directly improve the care of behavioral health recipients
- Consistently produce and use utilization data to inform decision-making; monitor case management utilization and cost data by contractor and program type; provide technical assistance for contractors regarding analysis and use of utilization data, as needed or requested; profile contractor's utilization of inpatient and outpatient behavioral health services; and use the findings of the over- and under-utilization assessment to improve the efficiency, cost-effectiveness, and quality of services to behavioral health recipients
- Ensure that quality of care complaints received anywhere in the organization are referred to Quality Management for investigation and resolution
- Communicate the resolution of concerns to the recipient/recipient's guardian
- Monitor the success of interventions developed as a result of recipient complaint/abuse issues
- Incorporate successful interventions into the Quality Management program or assign new interventions/approaches when necessary
- Track and trend behavioral health issue referrals by problem type, by program, and by contractor
- Compare trends to other available data to detect correlations
- Establish timeframes for the review and periodic update of the practice guidelines and conduct the review and any necessary updates in accordance with the timeframes
- Adopt an inter-rater reliability plan to ensure that standardized criteria are consistently applied to prior authorization decision making
- Monitor contractors to ensure their decisions to deny, limit, or change scope of service are not based on diagnosis
- Demonstrate and ensure that the results obtained from the Medical Care Evaluation studies are used to improve member care, member services, and provider facility performance

5. Finance

None

6. Encounters

• Review and correct encounter submission processes.

D. Review of Analysis Methodology

The OFR standards were rated based on the findings pertaining to the standard and using the following thresholds.

- Full Compliance: 90-100% of the requirements of the standard were met
- Substantial Compliance: 80 to 90% of the requirements of the standard were met
- Partial Compliance: 70 to 80% of the requirements of the standard were met
- Non-Compliance: Less than 70% of the requirements of the standard were met
- Not Rated: ADHS/DBHS was waived from the requirements of the standard

E. Assessment of Strengths and Weaknesses Related to Quality of Care, Timeliness, and Access

The Recipient Services, Delivery System, and Quality Management/Utilization Management domains contained the standards most relevant to quality of care, timeliness, and access.

The first OFR behavioral health Member Services standard and its three sub-standards were directly relevant to timeliness and access to care. ADHS/DBHS was required to ensure that appointments were available to individuals referred for services within the contractually required timelines and according to the needs of the behavioral health recipients. ADHS/DBHS was rated in full compliance with each of the three substandards. ADHS/DBHS was recognized for its strengths in requiring its contractors to make appointments available within the required timeframes and according to member needs. ADHS/DBHS monitored appointment standards through the annual ICR and the Quarterly Contractor Performance Improvement Activity Reports regarding access to care and appointment availability. RBHAs were found to have performed at a rate equal to or greater than the required 85% minimum performance standard for scheduling appointments for emergency services within 24 hours of the request and for determining that appointments for routine assessments were available within 7 calendar days of the referral or request for service. RBHAs also were found to have met or exceeded the 85% minimum performance standard for providing a routine appointment within 23 days of the initial assessment for services.

The seventh OFR Member Services standard also contained several elements related to access by requiring ADHS/DBHS to ensure that behavioral health recipients/families received information in accordance with 438.10(F) and 438.100 according to AHCCCS Contract YH8-0002, Section D. ADHS/DBHS received a rating of full compliance for ensuring that all behavioral health recipients were annually notified of their right to request and obtain the following information.

1. Name, locations, telephone numbers of, and non-English language spoken by current contracted providers in the behavioral health recipient's service area, including identification of providers that are not accepting new referrals

- 2. Any restriction on the behavioral health recipient's freedom of choice among network providers
- 3. Behavioral health recipient rights and protections
- 4. A description of how after-hours and emergency coverage is provided
- 5. A description of what constitutes an emergency medical condition, emergency services, and post-stabilization services
- 6. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent
- 7. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract
- 8. The fact that the behavioral health recipient has a right to use any hospital or other setting for emergency care
- 9. The fact that prior authorization if not required for emergency services
- 10. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that the behavioral health recipient understands the benefits to which they are entitled
- 11. Procedures for obtaining benefits, including authorization requirements
- 12. The extent to which, and how, the behavioral health recipient may obtain benefits from out-of-network providers
- 13. The post stabilization care services rules
- 14. Cost-sharing, if any
- 15. How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided
- 16. Advance directives
- 17. Information on the structure and operation of ADHS
- 18. Physician incentive plan
- 19. Grievance, appeal, and fair hearing procedures and timeframes that include the following
 - a. State fair hearing
 - i. The right to hearing
 - ii. The method for obtaining a hearing
 - iii. The rules that govern representation at the hearing
 - b. The right to file grievances and appeals
 - c. The requirements and timeframes for filing a grievance or appeal
 - d. The availability of assistance in the filing process
 - e. The toll-free numbers that the behavioral health recipient can use to file a grievance or an appeal by telephone
 - f. The fact that, when requested by the behavioral health recipient
 - i. Benefits will continue if the behavioral health recipient files an appeal or a request for State fair hearing within the timeframes specified for filing

- ii. The behavioral health recipient may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the recipient
- g. Any appeal rights available to providers to challenge the failure of an organization to cover a service

The first OFR Delivery System standard required that ADHS/DBHS ensure the sufficiency of its provider network to meet the behavioral health service needs of Title XIX and Title XXI members. Adequacy of the provider network is critical to timeliness and access to care. ADHS/DBHS received substantial compliance ratings for this standard. ADHS/DBHS was found to have sufficient network capacity for therapeutic foster care services and for respite services. ADHS/DBHS was also found in compliance for evaluating intermittently the sufficiency of its contractors' provider network, monitoring its contractors to determine if any material gaps or deficiencies in the network were addressed, and monitoring its contractors to determine that anticipated changes to the network were reported in a timely manner. The major weakness in this area was the finding that ADHS/DBHS did not maintain a provider network that was sufficient to provide all covered services to AHCCCS members, including prescribing clinicians in all The OFR report noted that, although ADHS/DBHS did not have sufficient prescriber capacity in rural and remote locations, they have created committees to address this issue, and are continuing efforts to recruit providers for these areas. AHCCCS has required ADHS/DBHS to develop a Corrective Action Plan to ensure that a provider network is maintained that is sufficient to provide all covered services to AHCCCS members, including prescribing clinicians in all areas.

There were both strengths and weaknesses related to quality of care in the OFR findings under the Quality and Utilization Management QM/UM standards. standard requires ADHS/DBHS to maintain a health information system that collects, analyzes, and reports data necessary to implement its quality management/quality improvement program. A rating of substantial compliance was given for the first sub-standard requiring ADHS to monitor the timeliness, completeness, accuracy, logic, and consistency of quality and utilization management data and reports to ensure the integrity of information and data reported to AHCCCS. The strengths were that ADHS was able to calculate encounter-based performance measures accurately, and ADHS did ensure that all behavioral health recipient information protected by Federal and State law was kept confidential. The weakness was that ADHS was not able to calculate encounter-based performance measures completely. The OFR comment was that, although ADHS did take corrective and curative actions, timely and complete encounter data was not received from two of its contractors during the period under review, necessitating a corrective action plan to ensure the receipt of timely and complete encounter data as required.

A rating of full compliance was received for the second and third QM sub-standards, acknowledging that the ADHS/DBHS Health Information System data did include the required data elements necessary for quality improvement requirements, and that ADHS/DBHS submitted timely, complete, and accurate Quarterly Showing Reports to

AHCCCS.

A rating of partial compliance was received for the fourth and fifth QM sub-standards. The recommendation for the fourth sub-standard was that ADHS/DBHS must systematically and consistently analyze grievance, appeal, expedited appeal, mortality, and incident/accident data as part of its Quality Management process. In addition, ADHS/DBHS must use the resultant data analyses to inform clinical and administrative decisions and to directly improve the care of behavioral health recipients. The recommendation for the fifth sub-standard was that ADHS/DBHS must consistently produce and use utilization data to inform decision-making, monitor case management utilization and cost data by contractor and program type, provide technical assistance for its contractors as needed or requested regarding analysis and use of utilization data, profile contractors' utilization of inpatient and outpatient behavioral health services, and use the findings of the over- and under-utilization assessment to improve the efficiency, cost effectiveness, and quality of services to behavioral health recipients.

The second QM standard requires ADHS/DBHS to determine acceptable rates for compliance for each independent case review indicator and to work with contractors to identify the need for corrective action plans and follow-up evaluation. This was an area of ADHS/DBHS strength. The findings were that ADHS/DBHS action was taken when contractors did not demonstrate performance improvement, that monitoring did occur to ensure that contractors implemented corrective action plans, that oversight of corrective action plan implementation was increased, that the quality and consistency of contractors' corrective action plans was strengthened to ensure targeted performance was achieved, and that interim monitoring of contractors' performance occurred.

The third QM standard requires ADHS/DBHS to resolve behavioral health recipient problems and have a structure and process in place to track and trend quality of care and abuse/complaint allegations. This was found to be an area of ADHS/DBHS weakness, as a rating of non-compliant was given for each of the three sub-standards. Recommendations requiring corrective action plans were that ADHS/DBHS must ensure that quality of care complaints received anywhere in the organization are referred to Quality Management for investigation and resolution, must communicate the resolution of the concern to the recipient/recipient's guardian, and must track and trend behavioral health issue referrals by problem type, by program, and by contractor.

ADHS/DBHS additional strengths related to quality of care were recognized through the awarding of full compliance ratings for all aspects of QM standards four, five, and six. Specifically, the OFR review team found that ADHS/DBHS conducted and submitted performance improvement proposals and reports as required. ADHS/DBHS developed and implemented performance measures for the Title XIX and Title XXI children's system of care that incorporated in-depth case review, behavioral health recipient and family satisfaction surveys, and functional outcomes. Moreover, ADHS/DBHS oversaw and maintained accountability for all functions for responsibilities described in AHCCCS Medical Policy Manual, Chapter 900, that were delegated to other entities.

Utilization Management standard five and several of its sub-standards were related to timeliness of care, and ADHS/DBHS strengths in each of these areas were recognized by findings of full compliance. Specifically, ADHS/DBHS was found to have a structure, process, and procedures to provide recipients with notices of action that complied with AHCCCS requirements. ADHS/DBHS was found to have monitored to ensure its contractors issued and carried out authorization appeal decisions within required timeframes, resolved expedited authorization decision appeals within three working days after the date the contractor received the appeal, and ensured its contractors appropriately granted timeframe extensions for service authorization decisions.

F. Conclusions

The methods, conduct, and feedback processes of the AHCCCS behavioral health OFR were consistent with the CMS protocol for monitoring Medicaid MCOs and PIHPs.² ADHS/DBHS was recognized by AHCCCS as achieving improvement from CY 03 through the CY 05 review cycles. In CY 03, 80% of the 77 standards were rated as being in full or substantial compliance⁵, while 81% of the 90 standards received one of these two top ratings in CY 04⁶. Improvement continued to be noted in CY 05, with 91.5% of the 106 standards rated as being in full compliance or substantial compliance. The CY 05 OFR findings were particularly noteworthy, as the requirements for achieving the compliance ratings were made more stringent in CY 05 compared with prior years.

G. Recommendations

Any CY 05 OFR standard receiving a rating of non-compliance should receive particular attention to improving the compliance rating during the coming year. ADHS/DBHS has submitted a corrective action plan to AHCCCS addressing these issues. There were five (5) standards with a non-compliance rating, one concerning the Delivery System program area and four (4) in Quality/Utilization Management. These standards included the following requirements.

- Monitoring to determine that ADHS/DBHS contractors and subcontractors provide second opinions as required
- Having a process in place for reviewing and evaluating quality of care complaints and allegations
- Resolving quality of care/service issues raised by behavioral health recipients, contractors, subcontractors, and other involved parties
- Having a structure and process in place to track and trend quality of care and abuse/complaint allegations
- Having a mechanism in place to ensure that inpatient facilities conduct MCE studies which meet Federal requirements

Any standard receiving a partial compliance rating also deserves special attention. There were three (3) of these, one in Grievance and Member Rights and two in Quality/Utilization Management as follows.

- Tracking, trending, and analyzing claim disputes for potential fraud
- Analyzing and using grievance, appeal, expedited appeal, mortality, and incident/accident data as part of the Quality Management process and to inform decision-making and improve the care of behavioral health recipients
- Monitoring each contractor's collection, analysis, and use of quality management/utilization management data to ensure that information is used to improve the quality of care to behavioral health recipients

There were two standards receiving a substantial compliance rating that are of such importance to the system of care that they deserve special attention to bring them into full compliance. One is the General Administration standard requiring ADHS/DBHS to have in place the organization, management, and administrative systems capable of fulfilling all contract requirements, including contract compliance monitoring. The second is the Delivery System standard requiring ADHS/DBHS to maintain a statewide network of subcontractors and providers that is sufficient to provide all covered behavioral health services, including prescribing clinicians in all areas.

References

¹AHCCCS, Quality Assessment and Performance Improvement Strategy, October 2004

²Department of Health and Human Services, Centers for Medicare & Medicaid Services, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at CFR Parts 400, 430, et al, (Final Protocol, Version 1.0), February 11, 2003

³Centers for Medicare & Medicaid Services, Medicaid Program; <u>External Quality</u> Review of Medicaid Managed Care Organizations. Final Rule, (Federal Register, 68 (16): 3585-638), January 24, 2003

⁴AHCCCS, <u>CY 05 Final Report of the AHCCCS Operational and Financial</u> Review of ADHS/DBHS, March 6, 2006

⁵AHCCCS, <u>CYE 03 Final Report of the AHCCCS Operational and Financial</u>
Review of ADHS/DBHS, February 6, 2004

⁶AHCCCS, CYE 04 Final Report of the AHCCCS Operational and Financial Review of ADHS/DBHS, January 28, 2005

V. SUMMARY AND RECOMMENDATIONS

A. Summary and Comparisons

The Balanced Budget Act (BBA) of 1997 requires that State Medicaid agencies provide CMS with an annual external, independent review of access to, timeliness of, and the quality outcomes of services provided by Medicaid Managed Care Organizations. The CMS Final Rule for External Quality Review (EQR) of Medicaid Managed Care, which implemented this BBA provision, also requires annual, independent, external review of prepaid inpatient health plans (PIHPs). This Final Rule further requires that the external review be conducted in a manner consistent with three published protocols, as follows.

- Validation of Performance Measures
- Validation of Performance Improvement Projects (PIPs)
- Determination of MCO/PIHP Compliance with Federal Medicaid Managed Care Regulations

The EQR activities can be performed by one or more organizations, but each of the three protocol-related activities must be incorporated into a single annual report by one EQRO. For the behavioral health managed care system for Title XIX and Title XXI members in Arizona, AHCCCS, as the State Medicaid agency, performed the required activities related to the second and third protocols above, and provided the information to the EQRO. An ADHS/DBHS independent contractor analyzed two performance measures, along with other measures monitored on an annual basis, through Independent Case Review (ICR). AHCCCS also provided the EQRO with the 2004 ICR Report, and the EQRO performed reliability testing on the selected measures.

The two performance measures for external quality review were as follows.

- 1. The disposition of the referral from the Primary Care Physician (PCP) or Health Plan was communicated by the behavioral health provider to the PCP or Health Plan within 30 days of receiving the request for service.
- 2. Behavioral health care was coordinated with the member's PCP, as required.

The data for these measures were analyzed and reported for CY 05 through the 2004 ICR contract awarded by ADHS/DBHS to an independent contractor. The 2004 ICR found 79.7% of adults and 85.2% of children had the disposition of their referral communicated to the PCP within 30 days of the request for service. For the second Coordination of Care (CoC) measure above, the 2004 ICR found 67% of adults and 81.5% of children had their behavioral care coordinated with the PCP as required.

The EQRO re-abstracted a sample of 30 of the ICR cases for each of the two CoC performance measures to test the reliability of the ICR results. There was concordance between the ICR and EQRO findings in 23 of the 30 cases for timely disposition of

referrals, and in 24 of the 30 cases requiring coordination of care with the PCP. The reliability testing confirmed that CoC performance statewide met or exceeded the minimum threshold.

The PIP selected for external quality review was *Coordination of Care: Coordination of Behavioral Health and Acute Care Services*, aligned with the second CoC measure above. The data for this measure from the 2004 ICR will be used as baseline information. Coordination for adults somewhat exceeded the minimum threshold for this performance measure statewide, but did not reach the goal, and coordination for children exceeded the goal but did not reach the benchmark. In the 2005 ICR report, the data for this measure will be stratified for adults into SMI and non-SMI. The study question is whether educational efforts and a formalized process for the exchange of information between behavioral health providers and PCPs will produce better coordination of care as measured by the percent of behavioral health care recipients whose medical records contain evidence of coordination with the member's PCP as required.

For the third CMS requirement for external quality review, determining MCO/PIHP compliance with federal Medicaid managed care regulations, AHCCCS performed its annual CY 05 Operational and Financial Review of 106 standards and substandards within seven (7) domains or program areas for behavioral health. ADHS/DBHS was rated in full and/or substantial compliance on 97 of the 106 standards/substandards, or 91.5%. Corrective action plans were required for 28 of the 106, or 26.4% of the standards/substandards.

B. Assessment of Progress

Arizona is a national leader in incorporating coordination of care expectations in their Provider Manual and specifying CoC standards in the ADHS/DBHS contract, requiring CAPs if performance across RBHAs does not meet minimum standards.

ADHS/DBHS has made progress in increasing the percentage of cases meeting or exceeding the minimum threshold performance standard of 60% for the two coordination of care measures. The percentage for the Standard 9 timely disposition of referral measure increased for adults from 69% in CY 03, to 75.4% in CY 04, to 79.7% in CY 05. For children with timely disposition of referral, the percentage was 78.6% in CY 03, 71.1% in CY 04, and 85.2% in CY 05. For the Standard 10 measure of coordination between behavioral health and PCP, the percentage was 52.4% in CY 03, 50.6% in CY 04, and 67% in CY 05. For children with coordination of care between behavioral health and PCPs, the percentage was 56.2% in CY 03, 47.8% in CY 04, and 81.5% in CY 05.

ADHS/DBHS has also shown consistent progress in performance ratings for the annual Operational and Financial Review. ADHS/DBHS was found in full or substantial compliance for 80% of the standards/substandards in CY 03, 81% in CY 04, and 91.5% in CY 05.

C. Recommendations

The abstraction of medical records is resource-intensive. Sampling methodologies reduce the volume of cases reviewed, but are also subject to methodological error, and the results can only be interpreted with a certain degree of confidence. The sampling paradigm currently employed for the annual ICR provides an acceptable confidence level and margin of error at the GSA or RBHA level, but not for each measure or for each age group or other population stratification. It is recommended that, for measures of particular importance, and certainly those used as the basis for performance improvement projects, the sampling should involve sufficient numbers to allow a 95% confidence level and five (5) percent margin of error for each stratification level.

The measure associated with the coordination of care performance improvement project needs to be precisely defined in the proposal or PIP plan, including specification of inclusion and exclusion criteria. The range of responses allowed during record abstraction should be reviewed and possibly expanded, and the instructions to abstractors should be reviewed for the possibility of improving inter-rater reliability. If the measure or the range of abstraction responses or instructions are substantially changed, or if the sampling methodology is improved, consideration should be given to having the baseline measurement start at the time the changes are made.

Presentation of data in a way that allows trending over time is recommended, particularly within the PIP timeframe. For trending to be meaningful, the measure definition and comparability of data collection methodology, analysis, and reporting within and across RBHAs must remain consistent over time. Consideration should be given to trending the number of Title XIX and Title XXI unduplicated member months by RBHA, as well as the number of member months served by the behavioral health system, alongside the data for the performance measure(s), as a way of assessing penetration rates and patterns of correlation by RBHA, and for the overall behavioral health system.

References

- ^{1.} Department of Health and Human Services, Centers for Medicare & Medicaid Services, Code of Federal Regulations. Title 42, Chapter IV, Part 438 Managed Care. http://www.gpoaccess.gov/cfr/index.html
- ^{2.} Centers for Medicare & Medicaid Services, <u>Medicaid Program; External</u>

 <u>Quality Review of Medicaid Managed Care Organizations</u> (Final Rule. Federal Register, 68(16): 3585-638), January 24, 2003
- 3. Centers for Medicare & Medicaid Services, <u>Protocols for External Quality</u>

 Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health

 Plans, February 11, 2003.

APPENDIX A

AHCCCS Behavioral Health Services Guide Map Demonstrating Acute Care Health Plans and RBHAs by County

APPENDIX B

Arizona Department of health Services/Division of Behavioral Health Services Map Demonstrating Geographic Services Area (GSA)



AHCCCS Behavioral Health Services Guide Exhibit A

Acute Care Health Plans and RBHAs by County

